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RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE AFRICA REGION WITHOUT RECOMMENDATIONS FOR FUNDING FROM GENERAL RESOURCES

SUMMARY

The present document contains recommendations for supplementary funding in countries in the Africa region for which no recommendations for funding from general resources are requested at the 1991 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

Country	Amount (United States dollars)	Duration
Benin	2 175 000	1991-1994
Burundi	10 035 000	1991-1993
Côte d'Ivoire	1 020 000	1991-1992
Guinea-Bissau	2 060 000	1991-1993
Niger	7 535 000	1991-1994

Summaries of individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

I. BENIN

U5MR: 150
IMR: 89
GNP per capita: $390

Child population (0-15 years): 2.2 million
Literacy rate (male/female): 37/16 per cent
Access to health services: 18 per cent

One-year-olds fully immunized against:

tuberculosis:	74 per cent
diphtheria/pertussis/tetanus:	42 per cent
measles:	41 per cent
poliomyelitis:	42 per cent

Pregnant women immunized against:

tetanus:	60 per cent

Elimination of dracunculiasis

1. The 1989 UNICEF Executive Board approved an integrated water supply and sanitation programme for the period 1990-1994 as part of the country programme of cooperation. It aimed to eliminate dracunculiasis (Guinea worm disease) from the Zou province, the most endemic region, and extended efforts begun in the previous programme. Eradication operations and surveillance began in the north of Zou province in 1987, and the results were analysed during an evaluation of the impact of the water supply and sanitation programme on the elimination of dracunculiasis from the area undertaken in December 1990. Results will be available by April 1991.

2. The National Conference on Dracunculiasis Elimination in Benin, held in December 1988, established the basis of a national plan for the elimination of the disease. The huge economic losses, increased school absenteeism and infectious complications, including the risk of tetanus, that result from the disease in endemic zones explain clearly the urgency of an eradication plan. It is estimated that Benin loses nearly 700 million CFA francs in agricultural revenue each year because of dracunculiasis. This heavy loss has encouraged the country to introduce the incidence of dracunculiasis as a new major criteria for selecting villages for the provision of water by pumps or wells.

3. Although concentrated in specific geographic zones, dracunculiasis afflicts all six provinces of the country. The purpose of this project is to go to scale nationally with dracunculiasis elimination. The goal is to reduce the number of cases to 50 per cent of the 1988 level in 1992, 10 per cent in 1993, 0 per cent in 1995 and to certify elimination in 1997. Specific objectives are to identify the resources and partners needed to eliminate the disease and to develop, promote and support activities to eliminate it in all endemic areas and villages.

4. The main strategies of the project are: (a) the integration of health education and community mobilization activities with water supply interventions (with or without hand-pumps) in accurately targeted zones; and (b) strengthening central and local capacity in epidemiological surveillance and eradication activities such as training and supervision. The strategy can be summarized as the identification of endemic areas, training villagers to monitor and prevent dracunculiasis, supporting the villagers with technical intervention and ensuring that all cases are detected and effective preventive measures are taken. Priority will be given first to the most endemic areas and villages in order to reduce rapidly the number of cases. Lessons learned during the last country programme in community organization, social mobilization, health education and training for effective community management will be applied in this project. Coordination, extension and eradication activities of epidemiological surveillance will be effected throughout the national territory in 1991.

5. One major strategy in both the water supply and sanitation and the primary health care (PHC) programmes was the creation and training of village committees in management to further community involvement, direction and cost recovery using the Bamako Initiative strategy. Other health and water supply projects had a similar strategy so that many villages in the country have local committees that direct their development.

6. The project will ensure regional cooperation with neighbouring countries. Its advisory role and epidemiological surveillance responsibilities necessitate technical and logistics support. The coordinating office remains an organ for the collection and dissemination of information, as well as for the conception, programming, training and supervision.

7. In each endemic village, a committee will be responsible for the organization of eradication activities. In many villages, there are committees to maintain a pump, to organize health care or to be responsible for social organization or development. Where no committees exist, a health development committee will be set up in consultation with villagers and village leaders. After training, the committee will be responsible for conducting a monthly incidence search, for preventing infected persons from contaminating water points, for promoting drinking water security and for the operation and maintenance of project interventions and water supply.

8. At the village level, surveillance will be set up in all endemic villages in the country. Advocacy and support for health education, water supply and PHC interventions will be targeted especially to the 28 sous-préfectures (sub-prefectures) with more than 200 cases. Broken pumps in all endemic villages with existing boreholes will be repaired or replaced. Village-level operations such as health education, chemical treatment of water and development of drinking water security methods will be targeted first to endemic villages in the 17 subdistricts with more than 400 cases of dracunculiasis, with possible extension to the 11 subdistricts having between 200 and 400 cases. In the Zou department, village-level activities are

already planned within the framework of the UNICEF-assisted water supply and sanitation programme. The proposed project will extend the methods developed and proven in Zou province to the other endemic areas.

9. At the national level, a geographical information system will be refined in collaboration with the UNICEF water supply, sanitation and environmental sanitation programme. It will integrate all topographic, geographic, administrative, epidemiological, hydraulic, existing infrastructure and project location data with a view to planning and coordinating eradication activities. This system will be directed by a coordinating office that will collect information that can assist eradication, such as monitoring the evolution of different activities and measuring their impact on dracunculiasis prevalence. The office will disseminate the results of this work to all partners.

10. In each endemic village identified, a monthly monitoring search will be organized and disseminated through the most appropriate structures. Other vital health information such as births, deaths, nutritional status and vaccination coverage can be collected at the same time. Annual epidemiological surveillance will also be organized. There will be searches in both primary schools and in villages. The searches will last, on the average, one week per district and may be extended over a period of two months, throughout the country, at the end of the dracunculiasis season. It is planned to hold a national seminar every two years to review the situation and reorient the programme to achieve eventual eradication.

11. In 1993, the first national evaluation by active case search will be undertaken to allow redefining and better targeting of eradication operations. A second national evaluation in 1995, including an active case search, will introduce the final phase of the elimination of dracunculiasis project. At this time, an external and independent evaluation team of experts led by the World Health Organization (WHO) will observe progress accomplished and participate in national active case detection.

12. The water department of the Ministry of Equipment and Transportation is responsible for village water supply. Criteria for the selection of borehole sites will include disease incidence, water points, population and the dynamism of the community as shown by the establishment of a committee. According to search results and based on the provision of water to each endemic village having more than 1 per cent incidence and neither a permanent well nor a hand-pump-equipped borehole, 562 additional boreholes are needed for dracunculiasis elimination. Infection sites lacking drinking water supply must be identified for the water department. The concerned project areas will be contacted about the necessity of having these priority boreholes.

13. In the absence of specific medical treatment, the emphasis in PHC will be on anti-tetanus vaccination in health centres, which will also be responsible for treating complications. The cleaning and dressing of wounds, as well as anti-tetanus vaccination, will help to reduce complications.

14. Modules for teaching about the prevention, treatment and implications of dracunculiasis will be developed and included in the training provided to village health workers in endemic areas as part of the UNICEF-assisted PHC programme. This training will focus on promoting water filtration or chemical treatment; preventing infected persons from putting their feet into water points; and the care and bandaging of emerging ulcers to prevent the dispersion of dracunculiasis larvae and secondary infection. Information on other eradication strategies will be disseminated in order to sensitize villagers during training.

15. At the national level, information campaigns will be undertaken through the mass media. A national dracunculiasis elimination day may be organized in all primary schools, and teaching materials will be prepared by the coordinating office.

16. Possible different eradication strategies and tactics and their viability must still be the object of operational research, which will be conducted in the field by non-governmental organizations (NGOs) and, more specifically, by Peace Corps (United States) volunteers. Documentation and monitoring of methods and impact are essential. The use of filters, which can be made at the village level (clay pots, sand and charcoal) and of cloth strainers as an interim measure, will be promoted. It is necessary to ensure their fabrication, demonstration and distribution, preferably by subsidized sale. As boiling or heating consumes much energy, the project will promote more economically appropriate methods, such as solar water cisterns that can raise the water temperature to 60 degrees Centigrade, which is sufficient to kill the cyclops (a crustacean that serves as the host of the Guinea worm).

17. Applied research on methods to ensure the provision of safe drinking water despite the absence of a hand-pump must address their viability, cost and profitability. Among the methods to be developed are: (a) the construction of buried cisterns near water courses that will fill during the rainy season and supply water during the dry season; (b) the promotion and subvention of home cisterns filled during the rainy season to conserve drinking water in the dry season; (c) the installation of a water filtration system on ponds and reservoirs; and (d) the production of communal filters.

18. Selective support activities for operations research, linked to the steady provision of inputs and detailed impact surveillance, will be initiated and continually sustained. In addition to operational research on eradication methods, on-site research on the use of water and the effect of its chemical composition on the cyclops population will be undertaken. Assistance will be available to researchers of the national university and others to study dracunculiasis.

19. In order to ensure correct exploitation of existing water sources, the programme will survey all endemic villages and repair or replace broken or abandoned hand-pumps, as necessary. Local maintenance systems will be put in place with village committees and local repair teams.

20. Among the major monitoring activities are the establishment and utilization of a geographical information system and a management information system to manage the information collected and target interventions. Monthly surveys will be undertaken in all endemic villages until the disease is eradicated. A village child register will be introduced to monitor health status as well as births and deaths. Studies will attempt to find any cases missed by the monthly system. Each year, a study will be undertaken in all primary schools. In 1991 and 1993, house-to-house searches will be organized in all villages.

21. The "triple A" approach (assessment, analysis and action) will be applied to maximize effectiveness at the community level. This approach will be taught to the village committee members as well as to the technicians responsible for the project.

22. There are three types of progress indicators: direct outcome measurements; village-based interventions; and national capacity. Direct outcome measurements will consist of the number of dracunculiasis cases, incidence levels, the number of villages at various incidence levels and the areas reporting no cases. At the village level, the number of active village committees, functional water supplies and ponds treated will be monitored. At the government level, the number of people trained and the programmes and activities directed to the problem areas will be monitored. Yearly internal evaluations before the major transmission season will allow for programme adjustment. An external mid-term evaluation is planned to ensure that the project is properly targeted. UNICEF will provide technical and support staff as necessary to implement components of the project.

23. Current activities in dracunculiasis elimination have developed strong linkages between the water and health sectors, as well as with several external support agencies. This project plans to continue to reinforce this collaboration, particularly with the Peace Corps and WHO. The Japanese International Cooperation Agency and a German volunteer agency are currently implementing a project to supply water to a number of endemic villages.

II. BURUNDI

U5MR: 196
IMR: 116
GNP per capita: $240

Child population (0-15 years): 2.5 million
Literacy rate (male/female): 53/32 per cent
Access to health services: 61 per cent

One-year-olds fully immunized against:

tuberculosis:	99 per cent
diphtheria/pertussis/tetanus:	82 per cent
measles:	73 per cent
poliomyelitis:	82 per cent

Pregnant women immunized against:

tetanus:	80 per cent

Primary health care

24. The UNICEF programme of cooperation for the period 1988 to 1992 was committed to supporting Government efforts, along with those of other major donors (including WHO, the World Bank and the United States Agency for International Development (USAID)), to establish a national PHC programme. This was included in the national five-year development plan (1988-1992) for Burundi and emphasizes social and preventive health care and structures favouring decentralization at the intermediate level (represented by the provincial hospital).

25. The strong political will of the Government to prioritize PHC activities has accelerated the process of decentralization of the health system begun in 1987 through community participation in health delivery services. UNICEF assistance to this PHC effort has focused on the areas of the expanded programme on immunization (EPI), control of diarrhoeal diseases (CDD), malaria control, control of acute respiratory infections (ARI), acquired immune deficiency syndrome (AIDS), maternal and child health (MCH) and nutrition. Achievements have been made especially in EPI, for which coverage of all antigens increased from 55 per cent in 1985 to 80 per cent in 1990.

26. Despite these successes, there are still many constraints to achieving the objective of "health for all" in Burundi. Health centres and hospitals are not functioning as they should, with problems including the lack of integrated services, inadequate services offered in terms of the needs of communities, insufficient stocks of essential drugs and health supplies, and a lack of motivation on the part of most health personnel. For effective implementation of the PHC system, cooperation between the administrative structure and the local health system will have to be increased, while the participation of communities in the management and planning of health activities at the peripheral level could be strengthened.

27. The strengthening of the peripheral health care system within the framework of the Bamako Initiative has been identified frequently as the best strategy to sustain health components that are already performing well (such as EPI) and to ensure that an effective quality of health services is delivered at peripheral and intermediate levels. Preparatory action to implement the Initiative started in Muyinga province in 1990 and focused on the rehabilitation of 14 health centres and one rural hospital serving a population of 340,000.

28. This proposal will extend the PHC component of the current country programme until 1993. Within this period, UNICEF support will be directed towards government efforts at both national and peripheral levels in the following areas: (a) management and coordination of PHC activities through greater community involvement; (b) support to specific PHC components; and (c) containment of the spread of AIDS and sexually transmitted diseases (STDs) among adults and adolescents. A total of 240 health centres and 21 rural hospitals in the country will be the focus of action during the programme period, with the goal of reaching all 16 provinces by the end of 1993.

Management and coordination of primary health care activities

29. Activities in this area will include further development of a technical unit in the Ministry of Health to manage and coordinate all PHC activities using the Bamako Initiative strategy. This will be done through the reinforcement of human resources, the provision of necessary training and the development of the capacity of central health personnel in relevant fields such as health economics. Five departments will be strengthened at this level in order to implement the Bamako Initiative: (a) the inspectorate general and health planning office; (b) the department of training and personnel management; (c) the department of hygiene and prevention; (d) the unit of epidemiology and statistics; and (e) the department of budget and drugs supply. Attention will be given to health service delivery; improvement in the quality of services offered, including the constant availability of essential drugs; better coordination between health centres and the community; increased community participation; and a stronger health financing system at the peripheral level. The health financing system will be based on the medical insurance card (carte d'assurance médicale), which is purchased annually and provides access to basic services in health structures, as well as on direct payment for services. UNICEF will also support the strengthening of the national health information system, the development of a PHC monitoring system and the intensification of social mobilization and the information, education and communication (IEC) system at central and peripheral levels.

30. The establishment of a reliable referral system between the different levels of the health system will receive relevant support, as this is a key element in the consolidation of the PHC programme. Accordingly, appropriate protocols will be designed to identify those cases to be referred, the wider use of partogrammes will be introduced and a communication system will be established between health centres and rural hospitals.

Support to specific primary health care components

31. Within this system, UNICEF will support specific priority components of PHC, such as EPI, CDD, malaria control, AIDS control, control of ARI and safe motherhood, with the aim of strengthening integrated action at the health centre level. This is important for the institutionalization of a national PHC system in Burundi. The standardization of the national information system, which will provide the Ministry of Health with data on PHC activities and their progress, will play a major role in this integration process.

32. EPI will focus on sustaining the universal childhood immunization coverage rate at 80 per cent for children under 11 months of age and women of child-bearing age, in addition to developing strategies for the eradication of polio and tetanus. In order to achieve those goals, close attention will be given to the differentiation of activities relative to each health zone; the determination of catchment areas and target populations; the identification and analysis of the drop-out rate and development of a system to reduce the rate; and the development of specific activities in the areas with the lowest coverage rates. An alert epidemic/outbreak response system will also be developed and the supply and condition of all vaccines and cold-chain equipment will be closely monitored.

33. Emphasis in CDD/oral rehydration therapy (ORT) will be on the establishment of ORT treatment rooms at all health centres and rural hospitals. Attention will also be given to the development of home-based ORT treatment. Water supply and sanitation activities will play an important role, with plans envisioned to integrate sanitation education into primary school health education programmes.

34. Malaria control activities will aim to provide proper diagnosis and treatment of the disease, including resistant cases, in health centres throughout the country by providing anti-malarial drugs and laboratory equipment and by training laboratory technicians and other health personnel in case management.

35. ARI activities will centre on the development of national standard therapeutic protocols and diagnostic capacities of personnel. Drug needs must be identified, amounts estimated and provision made for their supply. In order to work towards ARI prevention, mothers' capacity to recognize ARI will be strengthened.

36. The analysis of nutrition data with other epidemiological data will be an important requirement for the identification of areas and populations at highest risk, and for the development of plans of action. Activities are also under way to organize a national plan of action for the prevention of both goitre and vitamin A deficiencies.

37. Safe motherhood activities will seek to improve early antenatal care at all health structures in order to ensure that 95 per cent of pregnant women visit them at least once during pregnancy; to inform about and advocate birth spacing; and to ensure safe delivery conditions.

38. The main aim of action for AIDS and STDs is to contain their spread among adolescents and adults, especially girls and women. Most activities will centre on further development of protocols, strategies and diagnostic capacities to identify and slow the spread of AIDS and STDs. In addition, family planning activities and plans for condom distribution will be better coordinated and relevant counselling will be improved. Educational outreach efforts will involve primary and secondary school children, while specific approaches will be developed for those considered to be at high risk, including children not enrolled in schools. The growing problem of AIDS orphans will be more closely studied and relevant strategies identified.

III. COTE D'IVOIRE

U5MR: 142
IMR: 95
GNP per capita: $740

Child population (0-15 years): 5.9 million
Literacy rate (male/female): 63/34 per cent
Access to health services: 30 per cent

One-year-olds fully immunized against:

tuberculosis:	47 per cent
diphtheria/pertussis/tetanus:	42 per cent
measles:	41 per cent
poliomyelitis:	42 per cent

Pregnant women immunized against:

tetanus:	34 per cent

Primary health care and the expanded programme on immunization

39. The health situation in Côte d'Ivoire has been aggravated by the economic crisis and the effects of structural adjustment measures. The Government was forced to reduce its health services budget by 3 per cent and the amount earmarked for PHC by approximately 30 per cent.

40. The situation of children and women in Côte d'Ivoire remains disturbing. Health services are poor and there has been a chronic shortage of essential drugs and supplies in health units since 1989. The under-five mortality rate (U5MR) is 139 per 1,000 live births. Among children, diarrhoea is the primary cause of hospitalization. Acute dehydration ranks third among the causes of infant mortality, while malnutrition ranks fifth. The number of MCH centres is very limited, with only 70 centres for nearly 2 million children under five years of age. EPI target diseases are still rampant, although their overall incidence is lower. The maternal mortality rate (MMR) is estimated at 200 per 100,000 live births in rural areas and 30 per 100,000 live births in urban areas, although 60 per cent of the causes of maternal mortality could be prevented by adequate prenatal care.

41. Outside the towns, the PHC operational structure consists of 26 rural health sectors. Coverage for the various activities (treatment for malaria, diarrhoea and respiratory infections) continues to be low, however, and the present health system is incapable of meeting ever increasing needs. In addition, PHC activities are still carried out as part of vertical programmes, without reciprocal support.

42. The lack of essential drug affects the quality of care for diarrhoeal diseases, ARI, malnutrition and malaria. Several sectors have some experience with village dispensaries, but most are hampered by the lack of follow-up and supervision and the inability to obtain drugs at affordable prices.

43. Many women still die in childbirth; since 1986, MMR has risen progressively. In 1986, 586 maternal deaths per 5,000 deliveries were recorded at the Cocody University Hospital in Abidjan, the capital, and 907 in 1989. Preliminary reports for 1990 indicate more than 1,000 maternal deaths. This situation is more acute in rural areas, where nearly 70 per cent of deliveries take place at home. The reasons given for not using public health facilities include the lack of drugs and the distance involved.

44. Because of this situation, the Government recognizes the need to introduce PHC more rapidly. Steps have already been taken to reorganize the Ministry of Public Health so that it will be more responsive to the PHC approach and to implement a policy to supply essential drugs based on cost-recovery.

45. In 1990, a special effort was made to revitalize EPI, which reached 42 per cent in 1989 and reinforced both the operational capacity of health infrastructures and the development of human resources. Some 316 centres for developing the advanced strategy became operational, so that a total of 484 health centres and clinics are now carrying out regular vaccination activities. In 1991 and 1992, 150 new centres will be equipped.

46. According to an evaluation conducted in the south-east region in May 1991 among children aged 12 to 23 months, 93 per cent had been vaccinated against tuberculosis; 77 per cent with three doses each of diphtheria/pertussis/tetanus and poliomyelitis vaccines; 70 per cent against measles; and 50 per cent against yellow fever. Despite those efforts, geographical accessibility remains difficult and vaccination rates are poor in several rural health sectors. Because of "pockets" of epidemics in certain areas, the achievements of EPI must be rapidly consolidated and mechanisms of adapted epidemiological supervision must be instituted.

47. Through the proposed programme, the Government and UNICEF seek to integrate EPI with other PHC components in four rural health sectors, while continuing to accelerate EPI throughout the entire country. UNICEF will assist the Government in its efforts to develop a coherent, integrated and coordinated PHC policy based on the principle of the Bamako Initiative, which should result in a rapid improvement in MCH while sustaining the achievements of EPI. Because the 26 rural health sectors are actively involved in EPI, progress made in this area can rapidly be applied to the integration of the preventive and curative PHC activities.

48. The objectives of the PHC/EPI programme for the period 1991-1992 will be (a) to strengthen EPI activities; (b) to upgrade the quality of MCH care; (c) to support and strengthen current community self-financing efforts by supplying essential drugs; (d) to strengthen social mobilization and IEC activities in these areas; and (e) to provide technical support to the programme.

49. The programme will have two elements: (a) strengthening decentralized national services; and (b) promoting community participation.

50. The programme aims (a) to evaluate vaccination coverage by health sector in January 1991; (b) to rehabilitate the central warehouse and equip 150 new centres; (c) to strengthen the capacity of 20 MCH centres in pilot areas; (d) to enhance accessibility to and quality of services of 150 health centres; (e) to train 60 public health officers and 300 paramedical workers in PHC management; (f) to train 200 traditional birth attendants and 200 community health workers; (g) to supply 170 health units and 200 village dispensaries with essential drugs; (h) to formulate a three-tiered supervision and monitoring programme consisting of village health committees, sub-prefectures and rural health sectors; (i) to formulate an EPI disease watch programme; and (j) to develop social mobilization structures through personnel training, follow-up and the preparation of educational materials.

51. The social mobilization programme established to support EPI will continue concurrently with the technical and material components. It began with the training of technical and social staff in the 26 rural health sectors and the establishment of local committees, closely monitored by an interministerial team of 10 instructors. The programme will include the other aspects of PHC in order to generate awareness and enhance the community's commitment to promoting health on its own initiative.

52. Management and follow-up tools will be deployed for gathering information in the various fields. There will be regular follow-up, supplemented by a study of the dispensaries in 10 rural health sectors. Two national-level evaluations of vaccination coverage will be conducted in order to measure progress at the beginning and end of the programme period.

53. While the programme will be implemented by the technical services of the Ministry of Health, a partnership will be developed with the other participants in the health system, including WHO, NGOs and bilateral agencies.

IV. GUINEA-BISSAU

U5MR: 250
IMR: 148
GNP per capita: $190

Child population (0-15 years): 404,000
Literacy rate (male/female): 46/17 per cent
Access to health services: N.A.

One-year-olds fully immunized against:

tuberculosis:	90 per cent
diphtheria/pertussis/tetanus:	58 per cent
measles:	44 per cent
poliomyelitis:	58 per cent

Pregnant women immunized against:

tetanus:	29 per cent

Rural water supply and sanitation programme and well-diggers' training project

54. Two separate projects make up the water supply and sanitation programme in the current programme of cooperation (1989-1993). The rural water supply project and well-diggers' training project were developed during the first two phases of implementation (1979-1986) in the western part of the northern region, between the villages of Varela and Campada where 120 wells were constructed to benefit approximately 12,000 people. Nineteen teams of well-diggers, including a team of drillers, had been trained in construction techniques for improved wells, village mobilization and sanitary education.

55. Following the conclusion of the first two phases of implementation, the third phase began in 1987, with the aim of constructing 100 wells in the region between Campada (25 in the São Domingos sector) and Ingore (75 in the Bigene sector) to serve a further 10,000 beneficiaries. These sectors of the region of Cacheu, where rainfall is low and very sporadic, were chosen because they were most deprived of drinkable water sources.

56. During the third phase, the training of new well-diggers had to be interrupted due to the Government's financial constraints in paying technicians' salaries. An evaluation mission in 1988, which included the participation of the Danish International Development Agency (DANIDA), considered the project's execution and positive impact and proposed several recommendations, including an extension of activities.

57. The objectives of this new fourth phase (1991-1993) will include (a) ensuring community support for operating and maintaining the 220 wells constructed; (b) continuing well-diggers' training and refresher courses and transforming and upgrading the São Domingos school into a national training centre with improved curricula; (c) building 36 new wells per year in the Bigene sector to benefit 3,600 persons, thus meeting the national goal of 400 wells for the zone; and (d) progressively introducing manual pumps and of latrine construction into the project.

58. UNICEF will ensure the provision of materials necessary for the maintenance of wells already constructed and construction materials for new wells and improved latrines, and will also absorb some logistics overheads. Prior to their more widespread introduction, and in collaboration with the project for maintenance and animation in the rural water sector, 25 hand-pumps conforming to national standards will also be installed on constructed wells in communities that are willing to participate in maintaining and repairing the pumps. The introduction of a maintenance system with trained local mechanics, who are provided with tool boxes and bicycles, and the creation of a maintenance centre in Sao Domingos are foreseen.

59. The Ministry of Natural Resources is eager to develop a national standardized training programme and animation activities covering maintenance of water sources, hygiene and sanitation so as to reach a common approach and methodology and to avoid duplication of efforts. According to present forecasts, two teams per year totalling 12 people will need to be trained in seven-month courses. The overall government strategy is to drill 2,000 boreholes and construct 400 improved wells. Seven well-digging teams (28 persons) will be required in the near future to serve the regions of Gabu, Bafata, Biombo and Boloma/Bijagos. A survey will be undertaken to better assess the national needs of qualified well-diggers. UNICEF will help to expand and equip the well-diggers' school to include more classrooms and a canteen and dormitory.

60. A technically well-constructed water source does not automatically guarantee better health conditions in a village. Prior to improving well construction and sanitation activities, communities will be sensitized to the project's goals of participatory development and self-financing. Before starting a sanitation programme, it will be essential to plan and undertake knowledge, attitude and practice (KAP) studies. Great importance is attached to IEC activities. The project will benefit from the experience in the Gabu and Bafata regions in the eastern province in linking sanitary education about water with hygiene and sanitation issues. The introduction on a pilot project basis of low-cost improved, ventilated latrines in primary schools and health centres is proposed.

61. UNICEF will assure technical assistance to the project through the recruitment of (a) a project officer to serve as advisor to the national project director; (b) a United Nations volunteer as technician/mechanic who will cover training, mechanic maintenance and logistics; and (c) an expert hydrologist. In addition, a DANIDA-sponsored anthropologist will facilitate project monitoring, studies and operational research.

Training rural women for self-employment in improved food processing, storage and marketing

62. The project will be closely linked with the other water supply and sanitation project in the Gabu and Bafata regions, as well as with the social communications team. Since its inception, the World Food Programme (WFP) has ensured food support to the well-digger trainees. The Governments of Denmark and the Netherlands also provide vital support.

63. A technical interministerial committee will assure follow-up by consulting monthly reports on the development of activities, including the control of delivery and utilization of materials and equipment. A quarterly revision of progress will be made and the project will be evaluated every November. A mid-term review of the entire programme of cooperation is scheduled in 1991, with a final project evaluation in 1993.

64. While there is no immediate threat of food insecurity owing to the lack of agricultural production in Guinea-Bissau, there is evidence of micronutrient deficiency in certain groups, while widespread parasitic infestation, endemic malaria and diarrhoeal diseases among children reduce food absorption and intake. Food prices have also risen dramatically under the structural adjustment programme, and as survival strategies of urban and rural households are threatened, a decline in food demand is noticed, especially among poor and vulnerable groups. Therefore, the training of rural women for self-employment in improved food processing, storage and marketing is necessary.

65. Fruit and crop processing, storage and marketing are poorly developed in Guinea-Bissau. Women, traditionally in charge of these activities, are already overworked and have little time for learning new skills. Consumers are unaware of the potential nutritional and economic value of already available foods and are unfamiliar with new processed products. Together, these factors deprive both producers and consumers of a wider range of goods and restrict incomes for poor women. In the process, valuable food resources are wasted each year.

66. Safeguarding child and maternal welfare involves a range of interrelated measures. Economic measures are needed to avoid serious deprivation among vulnerable groups experiencing declining access to productive resources and employment. Ways need to be found to diversify diets, to teach overworked women new processing and management skills and to generate effective demand among potential consumers for a wider range of low-cost food.

67. This is a broad-based social communications programme that is designed to complement existing and planned fruit and vegetable processing initiatives implemented through the Ministry of Rural Development and Agriculture. Although UNICEF has had no involvement with that Ministry to date, the programme will provide the educational and mobilization inputs to complement the technical support being offered through the processing and storage upgrading project of the Food and Agriculture Organization of the United Nations (FAO). It will teach new or improved processing and storage skills and marketing, basic stock and accounting techniques. The UNICEF-supported component will also develop marketing material aimed at consumers.

68. The objectives of this collaborative FAO/UNICEF programme are (a) to encourage the efficient utilization of existing fruit and other potentially viable crops; (b) to raise incomes of women producers by improving returns to both labour and time; (c) to improve household food security among poorer sections of the community; and (d) to improve nutritional status and reduce

micronutrient deficiencies. Improved child welfare and the receptiveness of women to education and health programmes are indirect benefits anticipated by offering improved working practices and conditions to mothers.

69. The programme, operating in the regions of Bafata, Biombo, Quebo, Quinara, Tombali and the Bissau Green Belt, emphasizes the participation of local groups and intended beneficiaries, and each community will be encouraged to adapt the skills and techniques being offered to its own specific material needs and cultural context. The structure and membership of groups will be decided by women themselves, and care will be taken to see that new activities do not inadvertently raise overall workloads by overlooking linkages with other activities for which women remain responsible.

70. UNICEF inputs comprise four main components: (a) research and pre-implementation preparation; (b) the transfer of new processing and management skills; (c) education and mobilization; and (d) material support at the local level.

71. Using KAP surveys, the pre-implementation component will investigate existing processing, consumption and marketing activities for the groups of food crops covered by the project. The prevailing sexual division of labour in each project area and the likely impact on different types of new or improved crop processing will be assessed. Dietary practices will be reviewed. This research provides an excellent opportunity for information collection to update the situation analysis on women, and will, in turn, be fed into materials development and mobilization activities over the three-year duration of the programme.

72. The transfer of new processing and management skills will initially focus on improved cassava, based on experiences in Nigeria, but UNICEF technical assistance will also support teaching new techniques for fruit processing and storage and honey production. Basic courses in stock management and marketing will also be given, including storage and bookkeeping. The project will offer specific assistance to groups of women wishing to establish cooperative ventures.

73. Education and mobilization materials will be prepared both to convince producers of the potential market and to show consumers that the products targeted by the programme are nutritionally valuable and comparable to existing foods in both preparation time and cost benefit. Experimental television in Guinea-Bissau will develop, produce and broadcast appropriate supporting programmes to the channel's network of "community television". The UNICEF-supported social communication project is well placed to support the preparation of programmes and will assist with materials, transport costs and specific technical support for mobilization materials. Three technicians will be selected to participate in short production courses in Brazil or Portugal.

74. Groups of women may acquire start-up materials and credit from the UNICEF-assisted project, but these will be provided on a loan repayment basis. Successful examples of such schemes already exist in the south of Guinea-Bissau and will be duplicated. Training for new skills will be provided to local community members and, where necessary, assistance in manufacturing equipment will be offered.

75. A group of eight persons will be selected to work as local-level coordinators and trainers, providing technical assistance for the first two years of the programme. Existing rural development structures will be used to manage and supervise the programme. Over the three years, three reports by specialists will investigate the progress of acceptance by both producer and consumer groups of the new processes and products. Progress reports will be prepared at the end of the second and third years and a final programme evaluation report will be prepared by the Ministry of Rural Development and Agriculture.

V. NIGER

U5MR: 225
IMR: 132
GNP per capita: $300

Child population (0-15 years): 3.7 million
Literacy rate (male/female): 32/11 per cent
Access to health services: 41 per cent

One-year-olds fully immunized against:

tuberculosis:	25 per cent
diphtheria/pertussis/tetanus:	12 per cent
measles:	12 per cent
poliomyelitis:	11 per cent

Pregnant women immunized against:

tetanus:	18 per cent

Integrated primary health care

76. The proposed PHC programme falls within the framework of the programme of cooperation for the period 1990-1994 (E/ICEF/1989/P/L.7). Its objective is to accelerate the development of PHC in the Niger as part of the Bamako Initiative, the practical arrangements for which were still being negotiated when the Executive Board adopted the programme of cooperation. The goal of the PHC programme is to upgrade the assets available for reaching the target set in the current programme of cooperation for reducing the high infant mortality rates (IMRs), U5MRs and MMRs by 25 per cent. In 1988, they were estimated at 134 per 1,000 live births, 228 per 1,000 live births and 700 per 100,000 live births, respectively.

77. The current programme of cooperation was begun in the midst of an economic crisis that had sharply diminished Government investment capacity. The gross domestic product dropped by nearly 32 per cent between 1981 and 1987 because of the steady devaluation of export prices, particularly of uranium, the country's chief source of income. In addition, a persistent drought, which in 1984-1985 had been responsible for one of the most disastrous harvests in the country's recent history and had resulted in a deficit of 478,000 tons of millet and sorghum, is still adversely affecting farming. The Government has also incurred a heavy debt, and debt servicing absorbs 60 per cent of tax revenues.

78. The integrated PHC component seeks to maximize the cost-effectiveness of available resources. The major obstacle to instituting PHC in the Niger is the lack of continuity between the activities of village health workers (VHWs) (who serve 45 per cent of villages, where they provide minimum services) and the national-level health programmes, which have developed vertically. UNICEF will support Government efforts to increase and sustain vaccination coverage rates and promote the use of health services in order to help reduce IMR and MMR by offering quality preventive and curative care.

79. The PHC component for the period 1991-1995 will be based on the following strategies:

(a) Revitalization and extension of health centres, whose workers will become focal points for integrated and essential preventive and curative health care. These workers will support VHWs in their activities, particularly by monitoring and supplying essential drugs;

(b) Effective popular participation in the planning, management and evaluation of activities, and in the management of health centre resources. This management will continue at the village level and extend to the health centre level;

(c) Grass-roots action to mobilize, co-finance and control resources for the operation of health centres, to provide the necessary resources, including essential drugs, and to streamline their use and management.

80. Thus, the health system outside the towns will be able to ensure, in an integrated manner, effective coverage of the population through specific activities in the following priority areas: (a) MCH and family planning; (b) universal immunization; (c) malaria control; (d) CDD and ORT; (e) control of ARI; (f) education and nutrition rehabilitation; and (g) education for health and improved sanitation, particularly with a view to containing infectious and parasitic diseases such as AIDS and dracunculiasis.

81. The necessary bases will then be established for reaching the following targets:

(a) Between 1991 and 1992, increasing access to MCH services by 21 to 50 per cent for children under five years old and by 32 to 50 per cent for women of child-bearing age;

(b) Ensuring universal immunization by 1995 by vaccinating 80 per cent of children aged under 11 months for all antigens, and child-bearing women against tetanus;

(c) By 1995, reducing mortality caused by diarrhoea by 25 per cent among children under five years of age; attaining an ORT use rate of 60 per cent for children under five years old suffering from diarrhoea; and treating 90 per cent of children in case of cholera epidemics;

(d) Treating annually at least 50 per cent of malaria cases among children under five years of age, using the established treatment procedure;

(e) Treating annually at least 10 per cent of ARI cases, using the standardized treatment procedure;

(f) In the area of education and nutritional rehabilitation, reducing the current rate (20 per cent) of chronic malnutrition among children under 5 years of age to less than 10 per cent, convincing 50 per cent of mothers who frequently use health centres to feed their children properly in order to prevent and treat malnutrition, reaching a recovery rate of 25 to 50 per cent among children under five years old suffering from malnutrition and developing preventive activities for malnutrition control by consolidating the experiences of the UNICEF/WHO joint nutrition support programme and systematizing regular follow-up and growth promotion among 80 per cent of children living within a 15-kilometre radius of the health units;

(g) Promoting the use of essential drugs by upgrading the training of 100 staff members in management and 1,000 pharmacists in the more rational use of drugs; contributing to the development of 100 fund management committees so that they can play a role in the integrated development programme and contributing to the development of a system of grass-roots participation by establishing a local solidarity fund through the various community development activities; promoting education for health in order to upgrade the habits of at least 25 per cent of mothers in the departments concerned in nutrition, hygiene and infectious and parasitic diseases, including AIDS and dracunculiasis and eradicate dracunculiasis by 1995; in the area of social communication and mobilization, reactivating six radio-club centres by training 120 operators.

82. The main activities of the programme will be as follows:

(a) Maintaining the achievements of EPI while integrating other services;

(b) Analysing the current functioning of the health system at district, health centre and village levels (based on existing studies) and micro-planning of activities at the district levels in order to guarantee efficiency and sustainability in accordance with the principles of the Bamako Initiative;

(c) Training communities and health workers in the management and organization of health activities in order to ensure the acceptance of responsibility at the local level;

(d) Providing areas outside the towns with basic supplies of essential drugs, equipment and management and information tools for the health system.

83. The following specific activities will also be conducted in priority fields:

(a) EPI will give particular attention to (i) increasing the number of permanent vaccination centres from their present level of 166 to 320 operational centres by 1995, so that 80 per cent of vaccination activities should be carried out as part of the advanced, permanent strategy and the remainder as part of the mobile strategy; (ii) training 1,000 health workers in vaccination methods by including an EPI module in the health studies curriculum; and (iii) the recovery of health and other community development costs (such as water-point maintenance costs) from the sale of health cards;

(b) MHC/family planning services will be reinforced by (i) providing 250 health units and 2,500 village health teams with technical equipment and teaching materials for upgrading services; (ii) instituting a system for growth monitoring and promotion for children under five years old at 250 health units by 2,500 village health teams; and (iii) introducing new nutrition and growth monitoring methods and methods for children under five years old and nutritional surveillance of pregnant and nursing mothers in 250 health centres by 2,500 village health teams;

(c) Malaria control will emphasize educational sessions to be organized at least once a year by health centre workers in the villages serviced. The sessions will focus on topics related to malaria among children under five years old and pregnant women and means of malaria control;

(d) ARI activities will include (i) convincing the health authorities to establish a standard ARI treatment procedure; (ii) organizing, at least once a year, in villages within a 15-kilometre radius of the health centres, an educational session on ARI among children and the means of controlling related mortality; and (iii) annually treating at least 10 per cent of ARI among children using a standardized procedure;

(e) In the area of education for health, the National Department of Education for Health will be equipped to help strengthen an ongoing IEC health mechanism; one regional and five subregional units will be developed for the purpose of educational and social mobilization activities for health; and mechanisms for PHC self-management by village communities will be instituted in 2,500 villages in the departments of Agadez, Maradi, Tahoua, Tillabery and Zinder;

(f) AIDS control will focus on (i) IEC sessions on AIDS at 90 secondary schools; (ii) producing and broadcasting at least five radio and television spots and one information and public awareness film on AIDS in 1991; and (iii) training 10 IEC instructors by 1992;

(g) Staff training activities will include (i) retraining 1,000 health workers and 2,500 village health teams by supplementing their technical knowledge and training them in administration; and (ii) contributing to staff training through the annual allocation, over five years, of 35 nursing and midwife fellowships, two fellowships for a paediatrician and obstetrician/gynecologist in training and two dieticians, beginning in 1993;

(h) The main social mobilization/communication activities will consist of (i) training 2,500 leaders of samarias (a traditional Niger youth association for solidarity and mutual assistance in the villages) in health and nutrition education in the departments of Agadez, Maradi, Tahoua, Tillabery and Zinder; and (ii) training 300 leaders, including 150 women and 50 staff members, at department and district levels, in methods of popular social mobilization.

Estimated annual expenditure

(In thousands of United States dollars)

Country/programme	1991	1992	1993	1994	Total
Benin					
Dracunculiasis elimination	375	625	590	585	2 175
Burundi					
PHC through the Bamako Initiative	3 745	3 280	3 010	-	10 035
Côte d'Ivoire					
PHC/EPI	680	340	-	-	1 020
Guinea-Bissau					
Rural water and well-diggers training	690	645	369	-	1 704
Training rural women for self-employment	150	130	76	-	356
Subtotal	840	775	445	-	2 060
Niger					
Integrated PHC	2 269	1 793	1 738	1 735	7 535
Total	7 909	6 813	5 783	2 320	22 825